FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Illinois
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) KidCare

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
__X__ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Introduction

Illinois has created a continuum of health benefits coverage plans for low-income children in the State. The plans are collectively called KidCare. They are funded by Illinois general revenue funds (state only) and Titles XIX and XXI of the Social Security Act.

Illinois KidCare has successfully expanded health benefits coverage to over 121,000 children and pregnant women as of October 1, 2000, increasing to more than 132,000 as of December 1, 2000.

This success has resulted largely from the State's emphasis on outreach to find and enroll as many children as possible. Illinois has also greatly simplified the enrollment process. A shorter, full-color application form was developed as a joint application for Medicaid and SCHIP. Families can enroll in KidCare through the mail, much like a private health plan. Application agents in 1,408 locations are available to help families complete applications. Families can also apply in person at Department of Human Services local offices where, for years, families in need have sought assistance. Telephone applications have been used on a limited basis.

Illinois' children's health benefits continuum includes Medicaid. Prior to the State Child Health Insurance Program (SCHIP), Illinois Medicaid eligibility was set at the federal minimum levels, with no copayments or premiums for children or pregnant women. To coincide with the development of Illinois' SCHIP, Medicaid for children was renamed KidCare Assist. The original Medicaid program for children is referred to as KidCare Assist Base.

Illinois first expanded coverage under SCHIP with an expansion of Medicaid called KidCare Assist Expansion. Effective January 5, 1998, Illinois established a single income eligibility standard of 133% of the federal poverty level (FPL) for children from birth through age 18. At the same time, Illinois increased to 200% FPL the income standard under Medicaid for pregnant women and their babies. This plan is called KidCare Moms and Babies. Individuals enrolled in these plans have no cost sharing requirements.

Illinois launched its separate SCHIP with two plans, KidCare Share and KidCare Premium, providing health benefits to children through age 18 in families with incomes above 133% FPL and at or below 185% FPL. Coverage under these plans was first available October 1, 1998, and is similar to Illinois Medicaid coverage. Families with children enrolled in KidCare Share pay small copayments for services. Families with children enrolled in KidCare Premium pay modest premiums to the state in addition to small copayments. American Indian and Alaskan Native families with children enrolled in KidCare have no cost-sharing requirements.

At the same time, Illinois began KidCare Rebate which reimburses families with income above 133% FPL and at or below 185% FPL for all or part of the cost of purchasing private or employer-sponsored health insurance for their children. KidCare Rebate is funded entirely with state funds. The KidCare plans are summarized in the following table:

	KidCare Assist Base	KidCare Assist Expansion	KidCare Moms and Babies	KidCare Share	KidCare Premium	KidCare Rebate
Age	Children 0-18 Pregnant women all ages	0-18	Pregnant women and their babies to age 1	0-18	0-18	0-18
Income (% of FPL)	0-5 ≤133% 6-16 ≤100% 17-18 <50% Preg. Women ≤133%	Above Assist Base through 133%	>133% - ≤200%	>133% - ≤150%	>150% - ≤185%	>133% - ≤185%
Insurance Status	Insured or Uninsured	Insured or Uninsured	Insured or Uninsured	Uninsured	Uninsured	Insured
Medicaid or SCHIP Program	Medicaid	Medicaid SCHIP Expansion	Medicaid	Separate SCHIP	Separate SCHIP	State only
State Plan	Title XIX	Title XXI Submitted 12/31/97 Approved 4-1-98 Title XIX amendment submitted 2/23/98 Approved 4/14/98	Title XIX amendment submitted 2/23/98 Approved 4/14/98	Title XXI amendment submitted 11/9/98 Approved 3/30/00	Title XXI amendment submitted 11/9/98 Approved 3/30/00	State only
Effective Date	Longstanding	1-5-98	1-5-98	10-1-98	10-1-98	10-1-98
Federal Match Rate	50%	65%	50%	65%	65%	0%
Duration of Financial Eligibility	Children - 12 months [a] Preg. women 60 days postpartum	12 months [a]	Infants to 12 months [a] Preg. women 60 days postpartum	12 months	12 months	12 months

[a] Twelve-month continuous financial eligibility began March 2000 for children in KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies.

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter >NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility
   NC

2. Enrollment Process
   Beginning in May 2000, Illinois has allowed families to apply by phone on a limited basis. Callers to the KidCare hotline can be transferred to a KidCare representative who will take application information by phone. The representative completes the application on line, prints the application and mails it to the applicant with a detailed list of any required verifications. The applicant signs the application, attaches verifications and mails the application to the central KidCare Unit.

3. Presumptive eligibility
   NC

4. Continuous eligibility
   In March 2000, KidCare began twelve month continuous eligibility for all Medicaid children, including those funded through Title XXI as part of the KidCare Assist Expansion.

5. Outreach/marketing campaigns
   Outreach efforts were strengthened to reach target populations by the State's hard-to-reach outreach contracts awarded to community organizations that work with families who speak languages other than English and Spanish, with rural families and with immigrant families. The number and types of KidCare Application Agents were increased. Marketing materials, such as tattoos, coloring books and crayons, were added. A new KidCare logo, phone number and website were added that are more appealing to families, more representative and easier to remember.

6. Eligibility determination process
   Illinois has simplified some income verification requirements for KidCare mail-in applications. Instead of requiring income tax records and three months of business records for self-employed

persons, only one month of business records is now required. For families with no income, an explanation of how they meet living expenses is no longer required.

7. Eligibility redetermination process
   The KidCare Unit began calling families who have not returned their redetermination form. This gives families the opportunity to ask questions about their coverage. It also gives the state an opportunity to remind the family that if the redetermination information is not completed, coverage will end.

8. Benefit structure
   NC

9. Cost-sharing policies
   Families with children who are American Indian or Alaska Natives do not pay premiums or copayments effective 03/01/00.

10. Crowd-out policies
    NC

11. Delivery system
    NC

12. Coordination with other programs (especially private insurance and Medicaid)
    Beginning in July, all KidCare Share and Premium coverage is maintained by staff in the central KidCare Unit. Previously Share and Premium coverage for families who also had services provided through Department of Human Services (DHS) local offices was maintained in the local offices. Since some local office staff do not frequently encounter Share and Premium cases, centralized procedures will improve consistency in servicing these families. As part of this change, KidCare and the DHS local offices work closely to share information received regarding families who are covered by programs in two offices.

13. Screen and enroll process
    NC

14. Application
    An updated version of the application was released in June 2000 to make minor changes, and to reword some questions. We are developing supplemental application for day care subsidy applicants to pilot in the Chicago area in early 2001.

15. Other
    NA

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

As reported in the Title XXI State Evaluation Illinois submitted on March 30, 2000, KidCare enrollment at that time was 95,381. This was up from 81,567 in January 2000. 121,814 children and pregnant women had health benefits coverage in October 2000 because of KidCare, increasing to 132,513 in December 2000. Of the December enrollment, 119,535 are children. **The number of children covered by Medicaid and KidCare, 817,009 for December 2000 has increased by 131,223, or 19% since KidCare began in January 1998**.

The enrollment numbers are summarized in the following table and come from State eligibility data.

KidCare Enrollment			
	01/01/00	**04/01/00**	**12/01/00**
KidCare Assist Base and KidCare Moms & Babies Base (enrolled through mail in application)	26,753	37,833	61,693
KidCare Assist Expansion	35,981	37,068	45,916
KidCare Moms and Babies Expansion	4,999	5,038	6,512
KidCare Share	5,703	6,202	6,537
KidCare Premium	5,336	6,007	7,272
KidCare Rebate	2,795	3,233	4,583
Subtotal	81,567	95,381	132,513
All Other KidCare Assist Base Children	655,452	657,448	684,496
Total	737,019	752,829	817,009

Note: The 817,009 total enrollment number for December 2000 increases to 910,356 when children with medical coverage through Aid to the Aged, Blind and Disabled and children through the State's Department of Children and Family Services (child protection system) are added.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   Medicaid enrollment consists of children in the KidCare Assist Base and KidCare Assist Expansion plans and pregnant women and babies in the KidCare Moms & Babies plan. The number of individuals enrolled through SCHIP/Medicaid efforts is 114,121 persons, of which 101,143 are children. These figures come from State eligibility data.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   - According to recent Census data, the number of uninsured children in Illinois families with incomes under 200% of the federal poverty level (FPL) decreased by 110,000 from 1998 to 1999. A great deal of this progress was made in those families with incomes between 100 to 200% FPL, the same families that have been targeted through KidCare outreach efforts.
   - As of October 2000, about 900,000 children had health insurance through the KidCare and Medicaid programs, up from 786,000 children who were receiving health benefits in January 1999. The State is very proud of this record: a fifteen percent increase in the number of children insured -- over 110,000 more children with health insurance in 20 months.
   - In addition to funding the Medicaid and KidCare programs, the Illinois Department of Public Aid also partners with Cook County and the Suburban Primary Health Care Council to sponsor the Access to Care program. Access to Care subsidizes the cost of primary care for low-income individuals living in suburban Cook County who do not have health insurance and who are not eligible for Medicaid or KidCare. Access to Care has developed a network of physicians and other providers who have agreed to participate in the program.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   _X_ No, skip to 1.3

   ____ Yes, what is the new baseline?

   What are the data source(s) and methodology used to make this estimate?

   What was the justification for adopting a different methodology?

   What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3*.

In the March 2000 State Evaluation, Illinois only reported on the performance goals related to enrollment. Illinois specified in its Title XXI plan that the success of the program would be measured by the extent to which children received health benefits coverage as a result of the program implemented under the Plan. Most of the original performance goals, which were established in late 1997, did not address this measure. In the March Evaluation Illinois stated that it was too early to gather sufficient data to do a meaningful assessment of the State's progress in meeting the other performance goals. In December 2000, this situation continues. Illinois does not yet have sufficient data to report on the other performance goals.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Extend health benefits coverage among Medicaid eligible but not enrolled children.	By January 1, 2000, increase the percentage of children enrolled in the program who are eligible at the Medicaid standard in effect on March 31, 1997.	Data Sources: The population survey and enrollment data. Methodology: Numerator: Children enrolled in KidCare Assist Base through mail-in application – 44,388 on October 1, 2000 70,016 on December 1, 2000 Denominator: Number of uninsured children eligible for KidCare Assist Base and not enrolled (from population survey data) – 106,081 Percentage: 42% for October 1, 2000 66% for December 1, 2000 Progress Summary: Illinois continues to enroll large numbers of children eligible for KidCare Assist Base at the Medicaid income eligibility level in place prior to SCHIP. An important factor to finding and enrolling Assist Base children is Illinois' decision to combine Medicaid and SCHIP into one program. Also important to this effort is the State's commitment, through a wide range of outreach strategies, to promote KidCare to all eligible families.
Extend health benefits to optional targeted, low-income children.	By January 2000, enroll in Title XXI at least 50 percent of the estimated 40,867 optional targeted low-income children with family income above the 3/31/97 Medicaid standard but at or below 133% of the FPL.	Data Sources: The population survey and enrollment data. Methodology: Numerator: The increase in the base population from the time of the survey to January 2000. February 1999 = 24,621 October 1, 2000 = 43,756 Increase – 19,135 December 1, 2000 = 45,916 Increase – 21,295 Denominator: The total number of uninsured children as documented by the population

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(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		survey, 40,867. Percentage: October 1, 2000 – 47% December 1, 2000 – 52% Progress Summary: Enrollment of children in this eligibility category continues to show steady growth.
Extend health benefits coverage to targeted, low-income children.	By January 2000, enroll in KidCare at least 50% of the children whose family income is above 133% and at or below 185% of the FPL.	Data Sources: The population survey and enrollment data. Methodology: Numerator: The increase in base population from the time of the survey to January 2000. February 1999 = 1,508 October 1, 2000 = 13,104 Increase = 11,596 December 1, 2000 = 13,809 Increase = 12,301 Denominator: The total number of uninsured children as documented by the population survey, 43,835 Percentage: 26% for October 1, 2000 28% for December 1, 2000 Progress Summary: Illinois is still short of the original goal to enroll 50% of Illinois uninsured children with family income above 133% and at or below 185% of FPL. However, Illinois is making steady progress in enrolling theses children. KidCare Rebate is not factored into the above percentages and is a factor in reducing the number of uninsured children. This is because families often choose to take private insurance that they had not previously had for their children after learning about KidCare Rebate. At this time the State does not have reliable information on the number of Rebate families who were uninsured prior to

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		enrollment. If this data were available the above percentages would increase.
Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.	Launch a statewide outreach campaign through the coordinated efforts of the Illinois Departments of Public Aid and Human Services.	Data Sources: Department information on initiatives. Methodology: List of new outreach activities since the March 2000 State Evaluation. Progress Summary: Illinois has promoted KidCare using a wide variety of strategies. The diversity of these strategies and the State's significant contribution of resources to these efforts have been successful in enrolling over 130,000 children and pregnant women into KidCare. In addition to the outreach activities discussed in the March Evaluation, Illinois has started new outreach efforts. These include: ▪ Coordinating enrollment for KidCare with enrollment for the Child Care subsidy program ▪ Allowing families to apply by phone ▪ Community outreach work by Reverend Jesse Jackson and Rainbow/PUSH ▪ Spanish language television, radio and print advertising ▪ Advertising targeted to African American families ▪ Back to school advertising campaign in Springfield sponsored by Covering Kids ▪ New TV and radio ads produced for statewide general audience use ▪ Another round of statewide radio ads ran in the summer ▪ A second grant program for community groups providing enrollment and outreach services targeted to hard-to-reach families ▪ KidCare booths at county fairs in nearly all Illinois counties
Implement a statewide outreach and public awareness campaign	Increase the number of community-based sites certified by DPA to accept	Data Sources: Department provider information on KidCare Application Agents. Methodology: Compare number of KCAA provider sites in December 2000 to the number

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regarding the importance of preventive care and primary care for well-children and the availability of health benefits coverage through Title XXI.	eligibility applications for forwarding to and eligibility determination by the Central Statewide KidCare Unit.	in December 1998. December 1998 – 333 sites October 2000 – 1381 sites December 2000 – 1408 sites Progress Summary: Illinois has seen the KidCare Application Agent initiative grow into one of KidCare's most successful outreach strategies. The approval rate for applications from KCAAs has been consistently high and, in recent months, has surpassed 85%. The State will build on this success by adding Child Care Resource and Referral agencies as KCAAs.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Illinois is still developing plans to survey KidCare Share, Premium and Rebate enrollees to determine satisfaction with the program. Surveys of disenrollees are also under consideration. Also, Illinois would like to survey families about their health insurance history in order to understand KidCare's impact on crowd out.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

During Federal Fiscal Year 2001 Illinois will work to compile and analyze data related to the strategic objectives and performance goals that were included in the Title XXI State Plan but not reported above. These objectives related to improving the health status of children, improving access to quality health care for enrollees, and assuring appropriate health care utilization by enrollees.

1.7.1 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

The October 1, 2000 and December 1, 2000 Reports of KidCare Enrollment
The April 2000 KidCare Annual Report
The November 2000 KidCare Outreach Update
Data on enrollment of all Medicaid and SCHIP children

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

   Illinois does not offer family coverage in the SCHIP program.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults NA
   Number of children NA

3. How do you monitor cost-effectiveness of family coverage?
   NA

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

   Illinois does not have employer-sponsored insurance buy-in as a part of SCHIP. Instead, with all state funding, KidCare Rebate reimburses eligible families for the cost of monthly health insurance premiums that cover their children. Because of several stringent federal requirements, Illinois has not applied for and received federal match for Rebate.

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults NA
   Number of children NA For December, 4583 children are enrolled in KidCare Rebate.

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?
   Crowd-out occurs when families drop private insurance to become eligible for SCHIP.

2. How do you monitor and measure whether crowd-out is occurring?

Although Illinois has not yet gathered data on crowd-out, experience indicates that the state's two-part strategy to prevent crowd-out is effective. The first part is a three-month waiting period for children whose insurance was voluntarily terminated. In addition, Illinois implemented the 100% state-funded KidCare Rebate plan that refunds policyholders part or all of the cost of their children's health insurance premiums.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Illinois has not begun to track data on crowd-out; however, due to KidCare Rebate, the incidence appears to be minimal.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

KidCare Rebate is effective in discouraging crowd-out. KidCare Rebate is a 100% state-funded program that reimburses up to $75 per child per month to policyholders to cover the cost of health insurance premiums of commercially insured children. Assisting families with the cost of insurance reduces the incentive for policyholders to cancel commercial insurance to qualify for SCHIP. Currently, 4583 children participate in the Rebate program.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?
   - Illinois has contracted with KidCare Application Agents (KCAAs) to assist families in applying for KidCare at 1,408 locations throughout the state. KCAAs are community organizations such as hospitals, clinics, health departments, churches, insurance agents and others who inform families about KidCare and help families apply for the program. KCAAs are paid $50 for each complete application they submit that results in a new KidCare enrollment. Currently, KCAAs have an 85% approval rating for applications submitted.
   - Colorful and vivid brochures, applications and other materials describe KidCare as health insurance, not as welfare. Many advocate groups report that this has been effective in attracting attention to the program.
   - Illinois added a new easy to remember toll-free number, 1-866-4-OUR-KIDS, to the KidCare hotline. Families use the KidCare hotline to get information about the program, ask questions about the application, check on a pending application, get help in finding a provider, etc. The hotline continues to be a source of information for families. A TTY number, 1-877-204-1012, provides the same assistance.

- The Illinois Maternal & Child Health Coalition, as lead agency for the Covering Kids Illinois coalition, received a $1 million grant from the Robert Wood Johnson Foundation to assist with statewide outreach and enrollment efforts. They have allowed for provider and family involvement in the development of the program. Three pilot communities were established to represent diverse demographic areas of Illinois: city (Chicago/Cook County), suburban (DuPage County) and rural (Decatur/Macon County). KidCare has collaborated with Covering Kids Illinois on several projects including an outreach tool kit that has been distributed to over 5,000 organizations and individuals.
- Radio advertisements throughout the state have resulted in increased calls to the KidCare hotline and increased applications.
- The state is partnering with the Chicago Public Schools (CPS) to target KidCare outreach to children enrolled in national school lunch programs. The state and CPS are matching over 100 authorized KidCare Application Agent (KCAA) sites with specific Chicago schools to reach out to the target children and families to assist those families in applying for KidCare.
- Throughout the summer (June-August 2000), information was available at most county fairs in the state to promote the KidCare program. Local health departments or other KCAAs staffed many booths, while state KidCare staff had a presence at 26 county fairs.
- The Department contracts with two marketing agencies to develop television, radio and print advertising and media campaigns specifically targeted to African American and Spanish Speaking families.
- The Department is partnering with the Reverend Jesse Jackson and Rainbow PUSH to perform outreach activities to families throughout the State of Illinois. Outreach activities have included weekly meetings, assisting families in the application process and public events and mailings.

Effectiveness is measured by the number of applications mailed to families, the number of applications received and the number of calls that come in on the KidCare hotline.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

- The hard to reach outreach grants to community groups have been particularly effective in reaching families who are reluctant to participate in government programs, including immigrant and rural families and in reaching families who speak languages other than English and Spanish. In 1999, the state awarded $1.6 million in funding to 29 organizations to provide specialized outreach services to hard to reach populations throughout the state. Through September 2000, these community organizations have assisted over 8,800 families in completing the KidCare application and 188,000 individuals have attended events held by these organizations where KidCare is promoted. These community groups provided outreach in approximately 20 different languages. Effective November 1, 2000, a second round of awards amounting to $500,000 were awarded to 14 organizations to conduct outreach activities to targeted populations throughout the state.
- The Department partnered with a public relations firm in Chicago to implement a marketing plan

for the Hispanic community. Activities include sponsorship of the Ringling Brothers and Barnum & Bailey Circus, on November 25, 1999 and November 23-24, 2000, and other events. The group is also reaching out to families through community events, neighborhood festivals and parades. The ad agency has designed, produced and aired paid media to promote KidCare on television, radio and in print.

- The Department is working with a Chicago-based advertising firm to conduct outreach specifically targeted to African-American families. The outreach campaign consists of design, production and purchase of media time for television, radio and print advertisements featuring the Reverend Jesse Jackson. The campaign is targeting Chicago and other urban areas throughout the state.
- The Department is partnering with the Rainbow PUSH Coalition and the Reverend Jesse Jackson for KidCare outreach statewide. The Coalition has held community meetings, provided exhibit space and conducted KidCare mailings. Prominent Coalition members, such as Reverends Jesse Jackson, Willie Barrows and James Meeks, have worked with families to encourage them to apply for KidCare.
- The state is working with an organization to assist with outreach to employers. Through collaborative efforts, two employer newsletters were mailed to over 14,500 employers and 500 trade associations/chambers of commerce. A payroll stuffer was created, along with an outreach presentation designed to speak to employers and their employees. An Employer Guide was created to train employers in the process of assisting their employees in the enrollment process. This vendor has given numerous presentations to employers. KidCare is also collaborating with another group to reach employees through employers. A toll-free employer hotline was created and is staffed by this group to handle calls from employers seeking information or presentations on the program. They also have regular meetings with local business organizations to conduct orientations and training sessions on the various KidCare plans.
- KidCare has worked with several unions around the state to get information to their members about the plans. Several articles have been printed in various union newsletters and correspondence to members. Presentations and training have been provided to members and officials.
- Children from families speaking 38 languages other than English have been enrolled in KidCare. Of the 132,000 children enrolled in December 2000, 21.86% are African- American and 31.55% are Hispanic.

3. Which methods best reached which populations? How have you measured effectiveness?

Methods detailed in #2 above.

2.5 Retention:

1. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

As explained below, Illinois takes great efforts to ensure that eligible children stay enrolled in Medicaid and SCHIP. The KidCare Share, KidCare Premium and KidCare Rebate renewal process features several improvements. Plans are being developed to also make changes to the Medicaid renewal process. The SCHIP renewal includes:

- A preprinted renewal form mailed to enrollees 2 ½ months before their enrollment period ends.
- A follow-up renewal form mailed to families that have not returned the original form by the 30th day.
- Courtesy calls from KidCare staff to families that have returned neither of the first two renewal forms.
- Allowing families to complete the renewal by telephone and mailing verifications.

Another initiative that ensures children stay enrolled in SCHIP and Medicaid is continuous eligibility. Children are enrolled for twelve months of continuous eligibility both at initial determination of eligibility and at renewal.

Also, KidCare staff take every effort to move families between KidCare Share/KidCare Premium and KidCare Rebate in the simplest manner possible, without requiring completion of a new application.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

X Follow-up by caseworkers/outreach workers
KidCare representatives attempt to contact the families by telephone if no renewal form is returned.

X Renewal reminder notices to all families

KidCare representatives send a second renewal form if the first form is not returned within one month.

___ Targeted mailing to selected populations, specify population _____
___ Information campaigns
X Simplification of re-enrollment process, please describe

KidCare renewals originate centrally through a one page two-sided preprinted form (KC643KC) on which much of the information about the enrolled children is already preprinted. For example, the names of the children, their birth dates, and the address are printed on the form. Families only have to answer "Yes/No" to questions regarding address changes, health insurance coverage, pregnancy and residence of the children. The remaining questions deal with income and expense information for the household.

Another simplification is that renewals can be completed over the telephone with verification of

income being the only documents that must be mailed or faxed to the central KidCare Unit.

___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____

___ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

   SCHIP coverage for families who do not respond to renewal notice is automatically terminated at the end of the twelve months. For Medicaid families, local office caseworkers initiate the redetermination process.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

   The extensive follow-up of KidCare representatives at renewal is the most effective tool in ensuring that eligible children stay enrolled. Also changes that ease movement between programs and continuous eligibility work to extend coverage to more children for longer periods.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   Based on data collected by the central KidCare Unit, approximately 2.5% of SCHIP enrolled families are disenrolled at renewal because other insurance coverage was obtained. In addition, 0.2% are disenrolled because the family has access to State of Illinois insurance on the basis of a family member's employment with a public agency.

   The central KidCare Unit has begun to collect data on changes in coverage from a KidCare Share and KidCare Premium to KidCare Rebate at times other than renewal. Only eight to ten families per month of the nearly 9,000 families enrolled in Illinois' SCHIP program switch to Rebate during a month other than their renewal month.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   Yes. The initial mail-in application and renewal procedures are the same for Medicaid and SCHIP but the renewal procedures are different. There is no preprinted renewal form for Medicaid at this time. A DHS local office caseworker mails a blank renewal form to the family about a six weeks before the end of the enrollment period. The Medicaid family can:
   - mail the completed form and verifications to the local office,
   - complete the renewal by telephone and send verifications to the local office, or

- go to the local office to complete the renewal process.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

   Children enrolled in Illinois' SCHIP and Medicaid programs are guaranteed twelve months of income eligibility. SCHIP families are not required to report changes in income during that twelve-month period. However, if a SCHIP family reports a decrease in income to the Medicaid level and requests enrollment in KidCare Assist, a KidCare Customer Service representative cancels SCHIP enrollment and initiates Medicaid enrollment. When this occurs, there is no break in coverage. In fact, many times a family may have actually been eligible for Medicaid in one of the three previous months. In that instance, Medicaid enrollment is backdated and, if any premiums were paid under the KidCare Premium program for those coverage months, the premiums are refunded to the family. Computer coding in the refund action alerts fiscal staff to adjust the FFP claim. When a Medicaid family reports an increase in income in excess of the Medicaid level, the children continue to receive Medicaid throughout their twelve month enrollment period.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Any provider who is enrolled in the Medicaid program is simultaneously enrolled in the KidCare program. Providers may refuse to treat KidCare children if the family does not pay the nominal copayment.

   Of the six managed care organizations enrolled in the Medicaid program in Cook and St. Clair counties, four also accept KidCare enrollees.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   A formal assessment has not been made. We do track the number of KidCare Premium cases that have been cancelled for not paying premiums. For the reporting period FFY2000, fewer than 4% of the Premium cases have been cancelled for this reason. Of the families that we have an opportunity to talk to, very few mention cost sharing as a problem. Most say they did not know about the premiums or forgot to pay them.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   While the state has not formally assessed the effects of the cost-sharing on utilization of health services, we have anecdotal information that collection of copayment amounts is not often done by

providers, which is their option.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Fee-for-service (FSS): Illinois' ongoing Satisfaction Survey offers information on the quality of care received by enrollees in the KidCare Assist Base, KidCare Assist Expansion and KidCare Moms & Babies cases. For the time period of April 1998 – March 1999, these surveys revealed that an average of 96% of the respondents were satisfied with the quality of services they received. An analysis of a subsequent survey conducted in April 2000 is not yet available. KidCare Share and KidCare Premium enrollees are currently not being surveyed. Plans are being made to develop a survey for KidCare Share and KidCare Premium cases.

Managed Care Organizations (MCOs): MCOs are required to perform an annual member satisfaction survey. For the past three years, the survey was standardized, based largely on the Consumer Assessment of Health Plans Survey (CAHPS). The aggregate results of the 1999 Member Satisfaction Survey revealed that members in managed care were increasingly satisfied with the services they received and with their managed care plan. Following is a comparison of the results of the 1998 survey and the 1999 survey in several areas.

CUSTOMER SATISFACTION SURVEY
1998/1999 RESULTS COMPARISON

As reported by parents of children with managed care coverage

Question	1998 Results	1999 Results
Satisfaction with children's physician	82.2%	91.1%
Satisfaction with children's specialist	76.0%	86.4%
Satisfaction with children's managed care plan	71.9%	78.3%

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

The quality monitoring processes associated with Illinois' SCHIP are completely integrated with those used for Illinois' Medicaid program. This is true for managed care as well as fee-for-service.

The Department of Public Aid utilizes staff, professional consultants and contractors to provide technical and professional expertise to determine the appropriateness and quality of medical services being provided to recipients. Staff and consultants conduct:

- Peer reviews
- Recipient reviews
- Emergency room record reviews
- Hospital quality improvement plans
- Hotline referral invetigations

Analysts complete a post payment review of a sampling of paid claims from a variety of provider types. Data is compared to the norm established by geographic area and specialty. Types of providers reviewed include General Practitioners and specialists in Pediatrics, Chiropractic, Dentistry, Optometry, Audiology and others.

The Department monitors EPSDT utilization and separately tracks utilization for SCHIP enrollees.

The Department contracts with Central Illinois Medical Review Organization (CIMRO) to conduct reviews of inpatient utilization. Responsibilities include verification of medical necessity for admission and length of stay, determination of potential quality of care issues, validation of diagnosis and procedure codes, and compliance with Department policies and Administrative Rules. In addition, other special quality studies are performed as directed by the Department.

Under a separate contract with the Department, CIMRO is the External Quality Review Organization (EQRO) for the voluntary managed care program. In this role, CIMRO is responsible for medical record reviews and oversight and monitoring of the quality assurance programs of contracting managed care organizations.

The Department of Human Services (DHS) Office of Alcohol and Substance Abuse conducts annual post payment audits on a sampling of paid claims for substance abuse counseling and treatment providers. In addition, licensure and contract inspections are conducted on a regular basis.

The DHS Office of Accreditation and Licensure conducts a post payment review on a sampling of paid claims for mental health counseling and treatment providers. All agencies providing mental health services must be accredited by the Joint Association for Accreditation of Health Care Organizations and the Commission for Accreditation of Rehabilitative Facilities.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The Satisfaction survey for fee-for-service enrollees will continue to monitor and assess the quality of care received by Medicaid enrollees and the annual member survey for MCO enrollees will continue to monitor and assess the quality of care received by Medicaid and SCHIP enrollees in the MCOs. The Department will continue to develop a survey for KidCare Share and KidCare Premium enrollees.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility

Success

- One of the most unique and successful aspects of the KidCare program design has been KidCare Rebate. This plan has allowed the State to promote KidCare to all families without consideration of insurance status. This allows for a shorter explanation of eligibility requirements and promotes private insurance coverage.
- Illinois has simplified eligibility requirements as they relate to immigration status by offering health benefits coverage to recent legal immigrant children. This coverage is funded with state dollars as these children are barred from participation in federal means-tested programs.
- With the March 2000 implementation of 12-month continuous eligibility for Medicaid children, income eligibility for all KidCare children is effective for twelve months. KidCare Share, KidCare Premium and KidCare Rebate have had 12-month continuous eligibility since they began.

Barrier

- Federal eligibility requirements that vary between Title XIX and Title XXI programs are a barrier to a simple explanation of eligibility requirements. For example, children for whom Social Security Numbers are not provided must be denied enrollment into Medicaid. However, states may not require SSNs for children who will be found eligible for SCHIP. Illinois has informed enrollment workers of this policy difference, but it is a difficult policy to explain to families and to have staff apply consistently.

2. Outreach

Success

- The KidCare Application Agent (KCAA) effort continues to be one of Illinois' most effective outreach strategies. Many families successfully complete mail-in applications on their own, but some need extra help. KidCare offers several alternatives for families to receive help in applying for KidCare. KCAA staff are trained by KidCare training staff. KCAAs are paid a $50 Technical Assistance Payment (TAP) for each complete application that results in a new KidCare enrollment. The expansion in the number of participating KCAAs, $50 payments to KCAAs, and continuous KCAA training has been effective in increasing the number of applications received from KCAAs and significantly increasing the percentage of KCAA applications that are approved to more than 85%.
- Illinois' work to promote KidCare in a manner that appears more like private insurance than a government program continues to be effective in attracting interest to Medicaid and SCHIP and in changing the perception of Medicaid.
- KidCare has provided employer-based outreach to find families at work. Employers are often very

familiar with the insurance status of their worker's children and can assist in efforts to make eligible families aware of the benefits of health coverage. Employer based outreach has been especially helpful in informing families with private insurance about KidCare Rebate.

- Covering Kids Illinois sponsored a back-to-school public relations and advertising campaign to promote KidCare in the Springfield area. KidCare outreach staff worked closely with Covering Kids Illinois to develop this campaign. The results of the campaign were impressive. Calls to the KidCare hotline from the Springfield area increased by more than 250%. Applications received by the KidCare Unit also increased as a result of the campaign. Enrollment growth in the Springfield area was greater than in the rest of the state between August and December of 2000.
- Multi-media advertising has been very successful in promoting KidCare. Illinois's campaign has included TV, radio, print, billboard, and mass transit ads in numerous campaigns. General audience advertising has been used throughout the State. Spanish language television, radio and print ads and advertising targeted to African American families have run in Chicago and other media markets.
- KidCare community outreach has been strengthened by a partnership with Reverend Jesse Jackson and Rainbow/PUSH. PUSH is explaining KidCare to families in weekly meetings and assisting families in applying for coverage. The TV, radio and print ads targeted to African American families feature Reverend Jackson. Especially due to Reverend Jackson's renown, these ads have attracted a good deal of attention to KidCare.
- Illinois has used more than $2 million to fund special community-based outreach projects targeted to families who are hard to reach. This funding has allowed community based organizations to work with families who speak numerous languages other than English and Spanish and other special needs families to help them apply for coverage.
- Critical to Illinois' outreach success has been the outreach plan's diversity. No one strategy alone works to make eligible families aware of the program and to motivate them to apply. Most families hear about KidCare several times before they act. In addition to advertisements, community-based KCAAs, and employer based outreach, Illinois has also partnered with advocacy groups, business groups, medical and social services providers, community groups, schools, day care, and faith based organizations.
- The KidCare Fact Sheet, a one-page summary of KidCare, has been translated into Polish, Russian, and Arabic. The KidCare Fact Sheet is available in print format for distribution and is also available on the internet. The KidCare Fact Sheet will be translated into other languages over the next year.

Barrier

- It is difficult to simply explain what income levels qualify families for the program. Because income eligibility varies by family size, day care expenses, child support paid and other factors, it is difficult to explain to families when they might be eligible without doing a complete eligibility review. Robert Wood Johnson research indicates that successful advertising includes mention of an income level that families can use to judge whether they might be eligible. If this level is set too low, many families will be missed. However, if it is set too high, families will be frustrated to learn that they do not qualify even when their income is at the level mentioned in the advertising. Illinois, at this time has not mentioned family income in radio and television advertising. KidCare brochures do explain how income is calculated to determine eligibility and what the income eligibility levels are by family size.

3. Enrollment

Success

- Illinois' early decision to integrate Medicaid and SCHIP enrollment processes with one application has proven to be a good one. By housing responsibility for SCHIP plans with the Illinois Department of Public Aid, which administers Medicaid, Illinois has established, particularly through use of a joint application, a seamless enrollment process that allows families to apply for all programs at one time and assures that families eligible for Medicaid are enrolled in Medicaid.
- Illinois made a substantial commitment of staff and funding to create the central KidCare Unit. By centralizing processing of mail-in applications in one organizational unit, with offices in Chicago and Springfield, KidCare has been very successful in standardizing enrollment policy and procedures and prioritizing customer service. This has been key to creating a positive experience for KidCare applicants. Consistent processing procedures have also been important to the enrollment success of KCAAs.
- Prior to KidCare, most families went to a DHS local office to apply for health benefits through a process that often included a face-to-face interview. With KidCare and the use of mail-in applications, families have an alternative to scheduling appointments to apply for KidCare or to discuss their coverage with a KidCare representative.
- Illinois is also using telephone applications, on a limited basis, to allow another avenue for enrollment.

Barrier

- Illinois recognizes that requiring applicants to gather documentation to verify monthly income may be a barrier to enrollment for some families. This is especially true for low-income families who may be paid in cash and have no documentation of income. Illinois has taken several steps to simplify income verification requirements – no longer requiring families with no income to explain how they meet living expenses, shortening to one month the amount of documentation required from self-employed persons, and reducing income verification requirements for families also applying for the State's Child Care Subsidy program. The State has considered dropping front end verification but has opted not to take this step. The State is still committed to ensuring that families are income eligible for KidCare by requiring income verification.

4. Retention/disenrollment

Success

- Illinois has simplified the renewal process for KidCare Share, Premium and Rebate families whose first year of eligibility is coming to an end. Prior to the end of the first coverage period, the State sends families a pre-printed renewal form that contains current information about the family. The family updates the form with any changes, enters current financial information, attaches income verification and returns the form to the KidCare Unit for processing.
- KidCare has also instituted a procedure to call families who have not returned renewal forms. This allows KidCare staff the opportunity to explain to families that coverage will end unless the renewal process is completed and to answer any questions. This has been an important strategy to improving enrollment retention.

Barrier

- Non-payment of premiums is a retention barrier. However, it is not a factor for a large number of families. Roughly 4% of families enrolled in KidCare Premium lose coverage due to failure to pay premiums.

5. Benefit structure

Success

- Because Illinois made it a priority to have the separate SCHIP plans, KidCare Share and Premium, mirror the Medicaid plans, KidCare Assist and Moms & Babies, the benefit structures of these plans are nearly identical. This is important to families who move between programs and has allowed a simplified message for explaining the benefits for each plan. The very similar benefit structure has made it simpler for providers to serve KidCare families.

6. Cost-sharing

Success

- Illinois designed cost-sharing requirements that are well below the federal maximum. Under state law, the maximum copayment amount per family per year is $100. When added to monthly premium amounts, this maximum does not come close to 5% of family income.
- Illinois assists families in keeping track of how much they have spent for copayments. The Copayment Tracking Form is a multi-function form that allows families to store copayment receipts, record copayment amounts and notify the State when the maximum has been reached.

7. Delivery systems

Success

- Illinois' delivery systems for Medicaid and SCHIP are the same. Most families use fee-for service coverage. Voluntary managed care is available to families in Cook and St. Clair counties.

Barrier

- As Illinois enrolls more children and pregnant women into KidCare, issues of provider participation are being addressed. Illinois is working on several projects to improve provider participation.

8. Coordination with other programs

Success

- Illinois' complete integration of Medicaid and SCHIP enrollment with one application has been most successful.

Barrier

- Integration of Medicaid and SCHIP is hampered by requirements that differ by program. These include federal requirements related to Social Security Numbers and Medicaid eligibility backdating.

9. Crowd-out

Success

- The KidCare Rebate plan is an effective anti-crowd-out strategy. By offering premium assistance to families who would not otherwise be eligible for coverage because their children are insured, KidCare encourages families to stay with private insurance when it is available.

Barrier

- Gathering and analyzing reliable information on health insurance status for KidCare enrollees has been a challenge. With KidCare Rebate, crowd out should not be a problem. However, determining a process to test this theory is a challenge.

10. Other

NA

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	$2,257,335	$2,250,000	$2,250,000
per member/per month rate X # of eligibles			
Fee for Service	$43,891,069	$49,380,000	$65,097,000
Total Benefit Costs	$46,148,404	$51,630,000	$67,347,000
(Offsetting beneficiary cost sharing payments)	($927,114)	($1,279,000)	($1,839,000)
Net Benefit Costs	$45,221,290	$50,351,000	$65,508,000
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	$5,024,353	$5,594,000	$7,278,000
10% Administrative Cost Ceiling	$5,024,587	$5,594,000	$7,278,000
Federal Share (multiplied by enhanced FMAP rate)	$32,659,668	$36,364,000	$47,311,000
State Share	$17,585,975	$19,581,000	$25,475,000
TOTAL PROGRAM COSTS	$50,245,643	$55,945,000	$72,786,000

Note: Federal Fiscal Year (FFY) 2000 is October 1, 1999 through September 30, 2000). The HCFA 21 does not segregate admin costs, thus breakout is not readily available.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000. Illinois does not offer family coverage.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
__X__ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

There are no planned changes in the sources of the non-Federal share of plan expenditures.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	State Only Program
Program Name	KidCare Assist, KidCare Moms & Babies	KidCare Share, KidCare Premium	KidCare Rebate
Provides presumptive eligibility for children	_X_ No _____ Yes, for whom and how long?	_X_ No _____ Yes, for whom and how long?	_X_ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No _X_ Yes, for whom and how long? Up to 3 months prior to month of application for children in an approved case	_____ No _X_ Yes, for whom and how long? Prior coverage begins 2 weeks before the date of application and ends the day KidCare Share or KidCare Premium coverage starts. Prior coverage is only available the first time a child receives SCHIP.	_X_ No _____ Yes, for whom and how long?
Makes eligibility determination	_X_ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____ _____	_X_ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____ _____	_X_ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____ _____
Average length of stay on program	Specify months _7.24 months_	Specify months _6.53 months_	Specify months _6.56 months_
Has joint	_____ No	_____ No	_____ No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	State Only Program
application for Medicaid and SCHIP	_X_ Yes	_X_ Yes	_X_ Yes
Has a mail-in application	_____ No _X_ Yes	_____ No _X_ Yes	_____ No _X_ Yes
Can apply for program over phone	_____ No _X_ Yes On a limited basis	_____ No _X_ Yes On a limited basis	_____ No _X_ Yes On a limited basis
Can apply for program over Internet	_X_ No, can download application from Internet _____ Yes	_X_ No, can download application from Internet _____ Yes	_X_ No, can download application from Internet _____ Yes
Requires face-to-face interview during initial application	_X_ No _____ Yes	_X_ No _____ Yes	_X_ No _____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_X_ No _____ Yes, specify number of months _____ What exemptions do you provide?	_____ No _X_ Yes, specify number of months _3_ What exemptions do you provide? When insurance is lost through no fault of the family, when insurance is inaccessible and when insurance does not cover physician and hospital services.	_x_ No, requires child to be insured. _____ Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____ No _X_ Yes, specify number of months _12 *_ Explain circumstances when a child would lose eligibility during the time period – when child turns 19, moves out of home, is no longer an Illinois resident, was incorrectly determined eligible, or is a parent who refuses to cooperate with Child Support Enforcement	_____ No _X_ Yes, specify number of months _12 *_ Explain circumstances when a child would lose eligibility during the time period - when child turns 19, moves out of home, is no longer an Illinois resident, was incorrectly determined eligible, or is a parent who refuses to cooperate with Child Support Enforcement	_____ No _X_ Yes, specify number of months _12 *_ Explain circumstances when a child would lose eligibility during the time period – when insurance for child ends, child turns 19, moves out of home, is no longer an Illinois resident, was incorrectly determined eligible, or is a parent who refuses to cooperate with Child Support Enforcement
Imposes premiums or enrollment fees	_X_ No _____ Yes, how much? _____ Who Can Pay?	_____ No KidCare Premium Only _X_ Yes, how much? $15/mo 1 child; $25/mo 2 children; $30/mo 3 or more children	_____ No _X_ Yes, how much? Varies by private insurance coverage

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program	State Only Program
	___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____ _____	Who Can Pay? ___ Employer _X_ Family Anyone can pay; bill is sent to family ___ Absent parent ___ Private donations ___ Other (specify) _____ _____	Who Can Pay? ___ Employer ___ Family Anyone can pay; bill is sent to family ___ Absent parent ___ Private donations ___ Other (specify) __ _____
Imposes copayments or coinsurance	_X__No _____Yes	_____No _X__Yes Capped at $100/yr per family	_____No ____Yes Capped at $100/yr per family Varies by private insurance coverage
Provides preprinted redetermination process	__X__ No Yes, we send out form to family with their information preprinted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __X__ Yes, we send out form to family with their information and: _X_ ask for a signed confirmation that information is still correct; will accept phone call ___ do not request response unless income or other circumstances have changed	_____ No __X__ Yes, we send out form to family with their information and: _X_ ask for a signed confirmation that information is still correct; will accept phone call ___ do not request response unless income or other circumstances have changed

* The continuous eligibility period beings with the month in which the eligibility determination (or redetermination) is made and continuous for 12 months after that month.

5.2 Please explain how the redetermination process differs from the initial application process.

The initial determination of eligibility reviews all aspects of eligibility. These include residency, citizenship, insurance status, household composition, income and other things.

The renewal process KidCare Share, KidCare Premium and KidCare Rebate only looks for changes in information, focusing on income, household composition and insurance status.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

133% of FPL for children under age __6_____

100% of FPL for children aged _6 and older who were born after 10/1/83

*39% of FPL for children born prior to 10/1/83

*Based on a family of four

Medicaid SCHIP Expansion

133% of FPL for children aged 0 through 18

200% of FPL for children aged 0 to 1 when born to a woman receiving coverage under the Moms & Babies plan.

State-Designed SCHIP Program

150% of FPL for children aged 0 through 18 (Share)

185% of FPL for children aged 0 through 18 (Premium, Rebate)

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)
____ Yes __X_ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings **(a)**	$ 90/month	$ 90/month	$ 90/month
Self-employment expenses **(b)**	$ Actual	$ Actual	$ Actual
Alimony payments Received	$ 0	$ 0	$ 0
Paid	$ Actual	$ Actual	$ Actual
Child support payments Received	$ 50/month	$ 50/month	$ 50/month
Paid	$ Actual	$ Actual	$ Actual
Child care expenses **(c)**	$ Actual	$ Actual	$ Actual
Medical care expenses	$ 0	$ 0	$ 0
Gifts	$ 0	$ 0	$ 0
Other types of disregards/deductions (specify)	$ NA	$ NA	$ NA

(a) $90 disregard per month from earnings of each employed adult in the standard
(b) As defined by state policy
(c) Up to $175 per month per child age 2 and older; up to $200 per month for children under age 2

6.3 For each program, do you use an asset test?
Title XIX Poverty-related Groups _X_No ___Yes, specify countable or allowable level of asset test
Medicaid SCHIP Expansion program _X_No ___Yes, specify countable or allowable level of asset test
State-Designed SCHIP program _X_No ____Yes, specify countable or allowable level of asset test

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage
   Advocacy groups, legislators, state agency representatives and others have been meeting throughout the year to discuss family coverage. At this time, Illinois does not have plans or funding to begin to cover parents of KidCare children, other than pregnant women.

2. Employer sponsored insurance buy-in
   Illinois would like to find a simple way to earn federal match for the KidCare Rebate plan. In order to keep the program user-friendly for families, Illinois has chosen not to seek federal match because of several federal requirements that would complicate the program. Examples of such requirements include employer contribution requirements, cost-sharing requirements, and benefit package requirements.

3. 1115 waiver
   NA

4. Eligibility including presumptive and continuous eligibility
   NA

5. Outreach
   Illinois has designed and produced new television and radio advertisements. The state is considering a new statewide KidCare advertising campaign to include TV, radio, billboards, print and mass transit.

6. Enrollment/redetermination process
   Illinois is working to coordinate KidCare enrollment with enrollment for other programs that have similar eligibility requirements. This includes the Day Care Subsidy program, WIC, Migrant Head Start, the Earned Income Tax Credit, Unemployment Insurance and School Lunch programs. The Day Care Subsidy project will begin February 2001 and features a supplemental KidCare application that, when combined with the Child Care Subsidy application, constitutes a complete KidCare application.

7. Contracting
   NA

8. Other

Illinois is creating a Member Handbook, which will be given to KidCare families at enrollment. The Handbook explains KidCare, including: benefits, managed care and fee for service, changes to report and procedures to do so, general health information and how to file a complaint.